Ironwood Physicians, PC
Ironwood Radiology
Ironwood Cancer & Research Centers

Consent to Release Health Information

Patient Name: _____ Date: _____

I hereby authorize Ironwood Cancer & Research Ctrs and Urology Associates to use and disclose my personal health information to the individuals identified on this form. **Initials** _____

I approve and understand that the staff at Ironwood may leave detailed messages on my voicemail. **Initials** _____

Contact Name: ( )

Last *First* *M.I.* *Telephone*

Address: _____

City *State* *Zip*

☐Spouse ☐Family (Describe) _____ ☐Friend ☐Other (Describe) _____ Emergency Contact? ☐ Yes

Contact Name: _____ ( )

Last *First* *M.I.* *Telephone*

Address: _____

City *State* *Zip*

☐Spouse ☐Family (Describe) _____ ☐Friend ☐Other (Describe) _____ Emergency Contact? ☐ Yes

Contact Name: _____ ( )

Last *First* *M.I.* *Telephone*

Address: _____

City *State* *Zip*

☐Spouse ☐Family (Describe) _____ ☐Friend ☐Other (Describe) _____ Emergency Contact? ☐ Yes

1. I hereby authorize Ironwood Cancer & Research Ctrs and Urology Associates to use and disclose my personal health information to the individuals identified on this form.
2. I understand this may include information relating to communicable diseases, such as HIV/AIDS, STD, behavioral, and/or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
3. I understand that the individuals identified on this form will be treated by Ironwood Cancer & Research Ctrs and Urology Associates as individuals involved directly in my care and as such Ironwood Cancer & Research Ctrs and Urology Associates will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Cancer & Research Ctrs and Urology Associates.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ironwood Cancer & Research Ctrs and Urology Associates will not be affected if I refuse to sign this authorization.

Patient Signature _____ Date/Time _____ AM or PM (*circle one*)

Personal Representative Signature _____ Relationship _____ Date/Time _____ AM or PM (*circle one*)